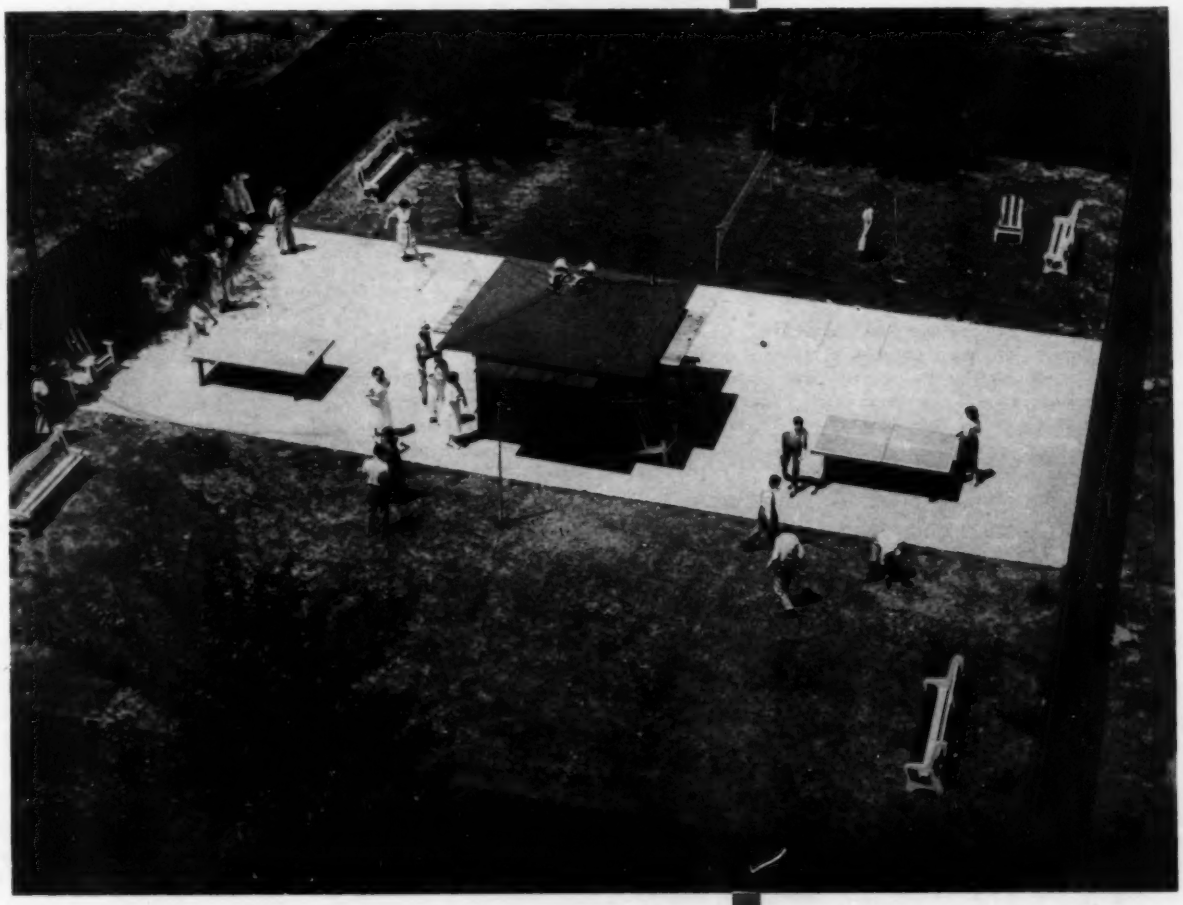
OCTOBER 1952

Mental Hospitals

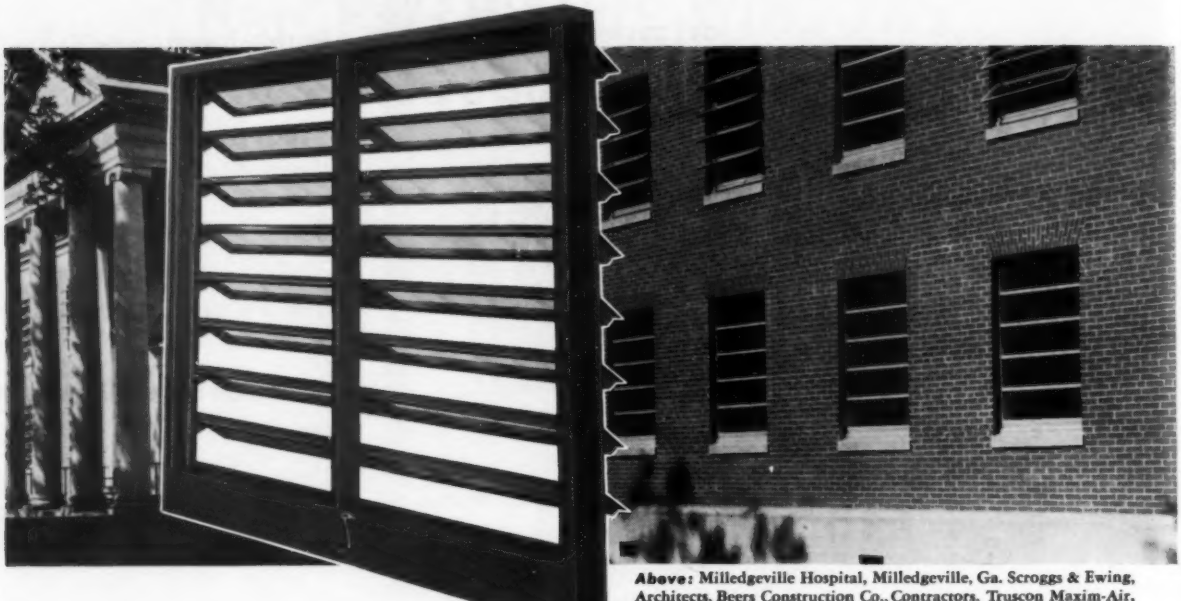
Volume 3 Number 8

In this issue:



Enclosed outdoor play area at the Neurological Hospital, Kansas City, Mo.

basis for beauty

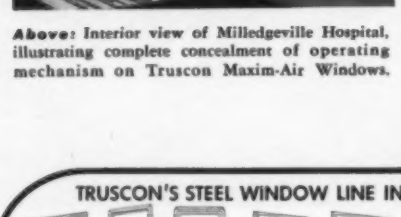


Above: **Milledgeville Hospital, Milledgeville, Ga. Scroggs & Ewing, Architects, Beers Construction Co., Contractors. Truscon Maxim-Air, Intermediate Projected, Basement Windows & Screens.**

Streamlined Truscon Maxim-Air Steel Windows

● All ventilators are top-hinged to open out, are mechanically controlled and open or close simultaneously by a completely concealed mechanism. The resulting elimination of unsightly arms and shafts permits the most convenient and effective arrangement of shades, screens and draperies.

Truscon Maxim-Air Steel Windows are ideal for use in warm climates, enclosed porches, solariums, or in any structure wherein it is important to provide free circulation of air in inclement weather as well as on sunshiny days. Detention type windows in this design can be made with glass heights as low as five or six inches for use in psychiatric institutions.



Above: **Interior view of Milledgeville Hospital, illustrating complete concealment of operating mechanism on Truscon Maxim-Air Windows.**

This unique Truscon development is offered in a wide range of designs and sizes. Architects are thus assured of an opportunity to design their requirements around specific needs without unduly restrictive limitations as to unit size and ventilator layout.

Above: **Exterior view of Milledgeville Hospital, showing Truscon Maxim-Air Windows in open position.**

FOR COMPLETE DETAILS and specifications, write for free catalog complete with installation data on Truscon Steel Windows for every type of commercial, institutional, industrial and residential use.

TRUSCON® STEEL COMPANY 1112 Albert Street Youngstown 1, Ohio

SUBSIDIARY OF REPUBLIC STEEL CORPORATION

TRUSCON'S STEEL WINDOW LINE INCLUDES ALL CONVENTIONAL TYPES PLUS EXCLUSIVE TRUSCON DESIGNS

EDITORIAL

PUBLICATION of the Diagnostic and Statistical Manual for Mental Disorders, early this year, was a step forward in solving the critical problem of collecting reliable statistics from 48 different state hospital systems. This A.P.A. publication contains a completely revised nomenclature and a definition of terms that is in general accord with modern concepts and practices. It further outlines basic principles and suggested procedures for setting up a uniform statistical reporting system. Nearly 10,000 copies are already in circulation.

Publication of the Manual was only a beginning. The need for a seminar on its use has become increasingly evident. The A.P.A. has authority to seek funds for such a seminar, and this is likely to be the next development in the field.

In the long run, the public and the legislators are not going to sustain a sympathetic attitude toward our requests for adequate facilities on the basis of guesswork only. It is incumbent upon those who have secured new buildings and facilities during recent years to demonstrate, with convincing statistical evidence, how these have paid off, if they have, in terms of patient improvement. While psychiatrists believe, for instance, that schizophrenics spend less time in the hospital today than they did before the introduction of newer therapies, even this simple fact is difficult to demonstrate concretely to legislators. If a statistical table can indicate reliably what a caseload is likely to be in a five year period, the superintendent then has a sound argument for a new intensive treatment building or whatever his need may be.

Progress in nationwide collection of adequate statistics is being made. The Biometrics Division of the National Institute of Mental Health, which has been responsible for the collection of data on a national basis since 1947, has now set up a Model Reporting Area, in which the hospital administrators and statisticians of eleven states act as an advisory group. Elsewhere in this issue will be found details of the work already accomplished, much of which has necessarily been exploratory.

At the Fourth Mental Hospital Institute, Dr. Jack Ewalt, Mental Health Commissioner for Massachusetts, Dr. Morton Kramer of the Biometrics Division of the N.I.M.H. and the undersigned will discuss the matter at greater length. It is our hope that other states will shortly begin the period of preparatory work which will be necessary before they can join the Model Reporting Area.

This problem should have high priority in our deliberations and program plans over the next three years.

G. N. RAINES, M.D.
Chairman A.P.A. Committee on Nomenclature & Statistics.

Mental Hospitals

October 1952
Volume 3 Number 8

CONTENTS:

Published monthly, 10 times a year, September through June, for staff members of mental hospitals, schools and related institutions which subscribe to the American Psychiatric Association Mental Hospital Service. Institutional subscription rate $2.50 a year. Individual subscription rate for staff members of subscribing institutions, $2.50 a year. Published by the American Psychiatric Association Mental Hospital Service, 1785 Massachusetts Avenue, N. W., Washington, D. C. Application for 2nd class entry pending at the Post Office, Washington, D. C.

Structural alterations need Careful Planning

BY PAUL HAUN, M.D.,
Asst. Prof. of Psychiatry,
Bowman Gray School of Medicine,
Winston-Salem, N. C.

Few public, tax supported psychiatric hospitals—or for that matter, private institutions—can boast of modern buildings exactly suited to the best contemporary medical practices. Reasons for altering their physical characteristics are many. Some house patients in structures which are far from fireproof; many are trying to make do with extemporized solutions to badly arranged facilities, inefficient equipment and too little space. With negligible exceptions, all are overcrowded.

Occasionally a legislature, recognizing the handicaps under which a hospital is attempting to function, dissatisfied with its location and convinced that the most ingenious efforts to improve its physical plant will give unsatisfactory results, authorizes a new hospital in a new location. Often, however, a clean sweep of this magnitude is not required and a highly satisfactory result can be obtained through alterations, additions and repairs to the existing plant. In such a case the superintendent should be ready with a carefully thought out, fully integrated and eminently practical plan.

It would be an exaggeration to say that no structural change can be made without repercussions in all of the hospital departments; yet it is certainly true that no such project, regardless of its scope, can be properly undertaken without a detailed top-level analysis of its implications on all phases of the hospital's operation. Like ripples on a pond into which a pebble has been thrown, the dislocating effects of the change are often felt in remote and unexpected places.

A common error is to undertake fragmentary, uncoordinated and piecemeal changes without first developing a master plan for the structural betterment of the entire plant. An X-ray department is in desperate need of modernization. We launch on the expensive task of correcting its deficiencies and as the last of the work goes into place, awaken to the painful realization that it occupies the one spot in the building where an ambulance entrance must be located. We add an 80-bed wing to our surgical building only to find that our clinical laboratory cannot handle the increased work load, that space for our Central Supply must be doubled and that our dietetic service is creaking dangerously.

There is much virtue in developing a master plan for each public psychiatric hospital, in carrying the staff work on it to completion, in assigning priorities to each of its elements and in dividing it into successive annual phases which can be presented at appropriate intervals to the enabling authorities. A method by which the superintendent, working in concert with a skilled architect, could approach the task, might be divided into the following steps:

1. Correction of Architectural Plans.

Few psychiatric hospitals were planned and constructed in their present form. Many have buildings ranging in age from 1 to 60 or even 70 years. The majority have been altered, some so extensively that little remains of the original structure but the walls. In certain instances the contractor was allowed to deviate from the working drawings without subsequent correction of the architectural plans. In short, it is a rare hospital indeed that has on file a complete and accurate set of drawings showing the site plan, the grade levels and each floor of all the buildings.

The first step in the development of a master plan is, then, literally pedestrian. It involves walking through each and every structure which the hospital calls its own with a steel rule, a collection of colored marking pencils and a set of drawings. Every stair is climbed, every door opened, every window checked and the location of every piece of permanent equipment verified. It is also of great value to note on the drawing the current number of beds set up in each patient bedroom, as well as the present utilization of each area when different from the blueprint designation.

A hospital of 1500 to 2000 beds can be accurately surveyed in 2 to 3 days by a team of 3 competent men. The length of time required for the correction of the prints depends, of course, on the manpower in the Engineering Department and the level of accuracy and completeness found in the available drawings.

There are strong arguments in favor of the superintendent's participating in all parts of the tour. The odds are excellent that he will learn many things about his hospital which he has forgotten or has never known. He will suddenly find it much easier to think of his institution in unitary terms. He will have a first-hand visual, tactile and olfactory comprehension of the whole institution which will be of great value when he begins to weigh the merits of suggestions for structural change.

2. Determination of Extent of Overcrowding.

A useful tabulation can now be made for each patient building and each nursing unit showing: (a) patient behavioral or diagnostic classification; (b) authorized capacity as carried by the Registrar's Department; (c) emergency over-capacity beds, and (d) tentative standard capacity. It is not impossible that beds will be found in rooms once used for offices, in patient lounges, in converted porches, in dining rooms, attics and corridors. Overcrowding in the bedrooms themselves will vary from building to building, as will the extent of encroachment on patient living space, diagnostic and treatment areas and the maintenance and housekeeping sections of the building. Bed spacing standards in effect when the hospital was built may no longer be satisfactory. Perhaps they were wrong to begin with. Perhaps subsequent relocation of radiators, or the placement of a new door or two into certain rooms has made the old bed arrangement impossible. Perhaps the behavioral classification of the patients has completely changed, resulting in new demands on the staff and new requirements for patient care never contemplated when the unit was built.

With accurate plans before him, with a knowledge of behavioral classifications in all patient buildings, and a fresh, first-hand memory of the actual conditions in every nursing unit, the superintendent has all the necessary data on which to determine the tentative standard bed capacity for each building in the hospital.

It is important to stress the fact that this determination of bed capacity is *tentative*. It represents the number of patients which the hospital can house without overcrowding within the limitations of its present facilities and affords a preliminary indication as to the direction subsequent planning must take. Can the overcrowding be corrected by changing admission requirements? Will new bed-containing buildings be required for certain patient categories? Is it time to urge the construction of another hospital to help carry the patient load?

3. Physical Reconstitution of the Hospital.

The tentative capacity may not and often will not reflect the level of medical care which, as a physician, the superintendent can professionally endorse. He will probably be able to present his problem somewhat as follows:

"We now have 3,000 patients in residence. A careful review of our situation shows that we are physically equipped to give *shelter* to 2,200. Of this number no more than 180 can now be given acceptable medical care. It is our professional opinion that all of those remaining would benefit greatly from an active treatment program. If our recommended plans are accepted, we estimate that up to 15% of our static patient group can be discharged on trial visit within six months; that another 20% can be moved to better wards within a year and that the adjustment and welfare of all patients in the hospital will be demonstrably improved."

Space does not permit discussion of the

(Continued on page 10)

The work of the Model Reporting Area

When in 1947 the Biometrics Branch of the National Institute of Mental Health was given the responsibility of collecting data on hospitalized mental illness, there was no dearth of information on patients in mental hospitals. A great deal of information was in existence, but it was buried deeply in hospital records, faithfully kept and carefully stored for twenty, thirty or forty years. But this bulk of information, even when adequately tabulated, presented problems in interpretation. Definitions varied, not only from State to State, but from hospital to hospital within the same State, and even, within a single hospital, from year to year.

The first years, therefore, were purely exploratory, but by 1951 the Biometrics Branch invited hospital administrators and statisticians of 11 States to form what was called the Model Reporting Area. This group was to aid in the establishment and acceptance of standard definitions, tabulations and classifications in order to achieve uniform and meaningful statistics about patients in mental hospitals.

These States were selected because they already had professional statisticians within their hospital systems and because the reporting of admissions to and separations from all hospitals within the State was to a central statistical office.

These eleven States—Arkansas, California, Illinois, Louisiana, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania and Virginia—represent 94 or 47% of the 201 State hospitals in the country. They provide care for a combined average daily resident patient population of 271,000, or 56% of the average daily resident patients in all State hospitals. They have 54% of all first admissions to all State hospitals in the country. They spend more than $223,000,000 per year for operating expenditures in State hospitals in the United States. They have an average over-all expenditure of $824 per patient each year—20% higher than the per capita expenditure in all other State hospitals. The eleven States account for a population of 72,500,000 people—or 49% of the total population of the country.

The second conference which met in 1952 recommended the adoption of uniform definitions and the annual preparation of a minimum number of basic tabulations. Specific definitions of "first admission" and "resident patient" respectively were approved so that uniformity would exist from State to State, thus making inter-State comparisons more valid. The conference recommended the adoption of 12 tabulations which would form the basis for data gathering, not only in the 11 States themselves, but ultimately in the other 37 as well. These tabulations, with a few minor modifications, are those suggested in the A.P.A. Diagnostic and Statistical Manual of Mental Disorders (pp. 61 to 72) and are concerned with movement, admissions, discharges, deaths, resident patients, patients in extramural care

(Continued on page 8)

Work placement of Defectives pays double Dividends

BY HORACE A. WHITE,
Supervising Social Worker,
Lapeer (Mich.) State Home & Training School.

THE ROLE OF THE SOCIAL WORKER in an institution for mental defectives is too often thought of solely as one which reaps many intangible benefits (in establishing a smoother liaison between the patient, his family, the institution, the community), but never shows any material dividends. This limited view is prevalent not so much because social work cannot justify its activities in terms which an auditor can appreciate, but because it seldom bothers to do so, or is not given the opportunity.

At Lapeer, however, our department has such an opportunity. We have under our supervision 156 patients who are fully self-supporting, and in some cases contributing to the support of their families. Their total yearly earnings is $230,751. If these 156 wage-earners had had to remain in the institution, in a year's time each would have cost the state $1,003.75 ($2.75 per day), or a total of $151,585 for all. No financial wizardry is required to see the obvious economy.

Our department can claim an honest share of credit for the success of the work placement program, along with the medical and psychology staffs, the work training department, and other school personnel who contribute directly to the program.

One of our responsibilities in this joint rehabilitation effort is to correlate the findings of the other departments in regard to the patient being considered for work parole. All during the period he is under consideration a social worker is in contact with him. The worker follows his progress in the work training department, where the patient must demonstrate stability in a job situation, and in the cottage and classroom where his ability to get along with other people is reflected in his relationships with fellow patients and with personnel.

When the patient is ready for work parole the social worker assesses his employability, as evidenced in his overall adjustment to the institution, and seeks to place him in a suitable job. This idea of suitability takes into account the other personalities with whom the patient will come into contact regularly, as well as the nature and complexity of work to be done.

Oftentimes the social worker's task really begins once the patient has been placed. There follow many hours of counselling and planning with patient and employer. Here is where the social worker's "typical role" as liaison agent comes into full play: adjustments must be arbitrated and encouragement given. When the patient gives clear indication he can continue on his own, he is discharged from the jurisdiction of the institution. The presumption is that he will continue to be, within the limits of his handicap, a respectable, self-supporting member of his community. A small preliminary study which we made indicates that 85% of the discharged patients are fullfilling this expectancy.

What has been presented so far is but a synopsis of the steps that lead up to the patient's discharge and is presented with emphasis on the active role of the social worker. There are several important factors involved in these steps which merit expansion.

First, of course, is the matter of deciding which patients are suitable to be trained for self-support. The patient should be free of psychosis and in good physical condition. He should display consistency in his habits and an even disposition. We believe that a person having an I.Q. of from 50 to 70 can be trained for self-support. There are slight variations in this range, however, for in the group of 156 parolees mentioned, the minimum I.Q. is 40 and the maximum 78. It is interesting to note, also, that those in the higher I.Q. bracket are not necessarily in the highest *income* bracket. (The highest yearly income of any of the 156 is $3700; the lowest is $1040, and the average $1550.)

In training the patient he should be placed in a job situation in the institution long enough for the staff to observe the kind of relationship he will sustain. He should constantly be taught punctuality and perseverance. Specific tasks assigned to the patient should graduate from simple to complex; thus the work training staff and the social worker can observe his threshold of frustration. The training jobs should be changed often enough to permit the prospective parolee to get a sense of variety in tasks he may be called upon to do in the community. It is desirable that he should be given an idea of *why* he is doing a certain job, of its usefulness, and why it is best to do it in the way he is being taught. Making him aware of the value of the tools and property he is entrusted with will also help him develop confidence in his ability.

His training should certainly not be confined to developing industrial skill. The

(Continued on page 10)

THE PATIENT DAY BY DAY

Training

MARYLAND INITIATES AIDE TRAINING COURSE

SPRING GROVE STATE HOSPITAL has been established as the center for psychiatric aide education in Maryland. State mental hospitals will send selected, qualified candidates, who, upon completion of the course, will return to their own hospitals.

The training is similar to that formerly given in the Menninger School for Psychiatric Aides, with emphasis upon psychiatry and basic nursing. The Spring Grove course includes ward administration and ward teaching. The course covers 385 hours of classroom work and 1700 hours of clinical experience under direct supervision. Upon completion of the training, graduates are prepared for teaching and supervision of non-professional nursing personnel.

During their training period aides are paid $2160 and upon graduation are advanced to $2400. Their maximum salary, after 5 years, is $3000.

Twelve out of fifteen students have successfully completed the first course. Heads of hospital services noted their success in resocializing the patients on the wards to which they were assigned. Boredom was eliminated by providing varying schedules of activity and recreation and the patients showed greater interest in their personal appearance and the attractiveness of their wards. As a result, the aides were in great demand on all other wards. (13-4)

Nursing Service

BLOCK SCHEDULE ABANDONED BY NORWAYS

AFTER TWO YEARS TRIAL of a "block" hour schedule experiment, nurses at Norways Foundation Hospital in Indianapolis have returned to the customary eight-hour shift, forty-two hour week. Under the "block" schedule the nurses worked twelve hours a day for four consecutive days a week.

During the first months the administrator and the director of nurses reported satisfactory results. But toward the end of the first year, general dissatisfaction became apparent. Nurses could not adjust to the change in their sleeping and eating habits; their efficiency decreased because of the 12-hour day and they found patient rapport hard to maintain on a four-day week.

The director of nurses found that communication between administration and nursing units was hard to maintain. Divided responsibility resulted in lack of co-ordination. It was difficult to carry out the in-service training program.

Now that the eight-hour daily shift has been resumed the director of nurses reports better organization, with clearer lines of authority and responsibility which benefit both patients and staff. (16-1)

Recreation

TRAINEE PLAN FOR RECREATION WORKERS

STUDENTS who are majoring in recreation at the University of Minnesota are offered a "trainee field work plan" at the state hospitals. By this program, advanced undergraduates may secure actual hospital experience. The students work with patients as well as helping in various phases of recreational programming under the supervision of the head Patient Activities leader or Patient Program supervisor, who is trained in recreation work. This field experience is correlated with classroom activities at the University.

Several of the full time Patient Activities workers now employed in the State hospitals have secured their recreation degrees as well as the field work experience under this trainee plan. (7-1)

Ancillary Services

LIBRARY BOOKS ON EACH WARD

A BOOKCASE with at least one hundred books is being placed on nearly every ward in Manteno (Ill.) State Hospital as the result of a project to extend the book service to as many patients as possible. Patients may keep volumes as long as they wish, and the customary procedure of signing books in and out will not be used.

In consultation with hospital, university and public welfare officials, the Illinois Federation of Women's Clubs launched a book collection program. To date, Manteno has received over 5,000 books, all of them good and even outstanding titles.

The furniture shop at the hospital has provided handsome bookcases. Books will be rotated from ward to ward every two or three months.

The books have been welcomed by the patients who are taking good care of them. In some wards patients have provided clean throws for the bookcase to keep the books free from dust. (23-2)

Volunteers

VOLUNTEER SERVICE TO BE EXTENDED

THANKS TO A VOLUNTEER SERVICE PLAN, recently introduced at Manteno (Ill.) State Hospital, many patients now have friendly contacts with the world outside the hospital. The program sought the aid of clubwomen who are trained to do such work.

So successful was the initial period that the service is now going to be broadened, and volunteers will learn, by means of films and lectures, the fundamentals essential to do satisfactory work with the mentally ill. The superintendent of the volunteer service will coordinate the program.

Upon completion of two five-hour instruction periods, volunteers will be asked to give at least 100 hours a year in service with freedom of choice about the days and evenings they wish to work.

During their service volunteers will be offered additional training in the field of mental illness through films and lectures. Distinctive pink smocks were provided for them by the Friends of the Mentally Ill. Patients often respond more readily to the influence of the volunteers than they do to routine care. The voluntary work will of course continue to supplement rather than replace the care given by salaried employees.

AUXILIARY VOLUNTEERS HELP WITH ACTIVITIES

TWENTY DIFFERENT CLUBS, church groups, home demonstration groups and civic organizations have cooperated with a volunteer Auxiliary at the Benton Unit of the Arkansas State Hospital to help with patient activities of all types.

The organizing group cooperated closely with hospital personnel, so that all projects could be properly planned for patient welfare and participation. Every effort is made to bring activities from the outside world into the hospital wards.

Relatives and friends of the patients were so impressed by the value of the work done by the groups that numerous letters of thanks were received as well as requests for permission to take part in the programs.

The Auxiliary itself plans six major projects a year at which time all groups combine to make the program a success; such occasions are festivities like the Fourth of July and Christmas. Once a month representatives from each separate group come to the hospital with a planned entertainment, which always ends with a trip to the canteen for refreshments. Music programs, popcorn parties and coffee sessions are popular. All programs are planned to encourage active participation by patients.

Major activities do not stop short with recreation and entertainment programs. The Auxiliary has secured reading glasses for four hundred patients, has collected for and supplied equipment for the hospital band and for outdoor sports. It has presented the recreation department with two wagons to be used in delivering supplies to the various wards and has supplied large coffee pots for all the recreation centers in the hospital. It has also secured six American and two Arkansas flags for display in the grounds.

The project requiring the largest outlay of Auxiliary funds was the beautification of the Auditorium, and the presentation of ecclesiastical equipment so that it could be used for Sunday services. Contributions included a new piano and four large exhaust fans, and a large illuminated religious picture for Sunday use. (9-1)

A dual approach to withdrawn patients

BY GWEN TUDOR, M.A., R.N.,
Chief, Psychiatric Nursing Section, National Institute of Mental Health

A PROBLEM which exists on many hospital wards without the staff being aware of it is that of "mutual withdrawal". This is a self-perpetrating cycle whereby ward personnel stop spending time with regressed patients, who thereupon withdraw still more and thus make themselves even less likely candidates for extra attentions.

This problem has critical significance in patient care because it hampers the patient's initiative to respond to treatment as well as the nurse's (or aide's) ability to function therapeutically. For this reason, the writer and Dr. Morris S. Schwartz, a research sociologist, conducted a six-month study in a 14-bed ward for disturbed women in a private psychiatric hospital.

Relationships with withdrawn patients are often so uncomfortable and anxiety-provoking that personnel avoid these patients, not always being aware of the reasons for or extent of their avoidance. Since this unawareness was the key factor in the "avoidance-withdrawal" problem, we decided that one workable solution might be developed by merging certain concepts and skills from two disciplines—those of sociology and psychiatric nursing.

From this idea, the "sociopsychiatric" approach resulted. First, a patient's responses to the personnel and their reciprocal responses were noted; second came discussion and evaluation of these observations with the sociologist; third, alternative plans of approach were formulated and instituted; next, the results were observed for success or failure, and finally came a further evaluation and when necessary, the formulation of new plans of action.

This approach enabled the psychiatric nurse to experience the patients as people and to become aware of their feelings, attitudes and ways of relating, as well as of her own reactions. The sociologist, with a broad perspective of the total social situation, pointed up relationships between the various situations that occurred with patients and the total social structure of the ward. For example, repeated failures on the part of those caring for a withdrawn patient eventually resulted in a general ward attitude that the patient was hopeless, which negated further attempts to approach this patient except for necessary routine care.

Although the study was done by a psychiatric nurse, its findings can be adapted to all personnel who work directly with patients, particularly the aide who has as much, if not more, opportunity to apply them. (In fact, in one of the cases we studied in detail, the task of establishing a relationship with the patient was accomplished by a student nurse, who was partially relieved of other ward duties in order to work with the patient and consult with the investigators.)

The nurse or attendant, in carrying out clinical functions with mental patients, has another responsibility as important as giving hypodermics and pills. This responsibility is the attitude with which she performs such routine nursing duties. It is not enough that her psychiatric orientation has taught her "what to expect" from mentally ill patients, and "how to handle" them. She must, if she is to minister to more than physical discomforts, be aware of the interpersonal relationships on the ward, the reactions of individual patients and personnel to each other, which determine the social context and climate of the ward. This awareness is the first step in developing a sociopsychiatric approach.

The need for objectivity was pointed up in one case in particular. The patient was a paranoid schizophrenic, given to shrill exclamations, explosive giggling, frequent spitting, vomiting and incontinence. The ward personnel were completely unaware that they were avoiding her, and when questioned would maintain that this patient received just as much personal attention as any other on the ward. Closer questioning revealed that they not only could not recall any specific examples of contact with her, but would turn the conversation to other matters, still unaware that they avoided this patient even in conversation.

Another patient, however, was deliberately avoided on the grounds that she "seemed happiest when left alone." There seemed some justification for this belief since the patient frequently flared into shouting, kicking and hitting at staff members who approached her. When left to her own devices she was inactive, remaining in bed most of the time, and mute except for periodic outbursts of abuse directed at the staff, the hospital, and herself. These outbursts, usually occurred when some demand was made of her.

In both cases the first step was to establish communication with the patients. Approaches had to be made at their prevailing level of response. If our attempts at conversation were ignored, we sat with a patient in silence as a first step. When finally she was able to make verbal responses and would take part in group activities, we felt that she could then hold her own in competing for personal attention.

Specific methods of achieving this varied considerably in each case, of course, but all fell within the framework of the sociopsychiatric approach.

Of the two patients discussed, the one stopped her spitting and vomiting, and her incontinence decreased greatly. Her psychotherapist observed that she was working out her negative feelings in therapy, probably because the healthy aspects of her personality had been encouraged and developed with the nurse and she was thus able to deal with her negative feelings with more comfort. The other withdrawn patient, who had been labeled "hopeless", also began to make some progress in her analytic sessions.

We concluded that such labels as "hopeless" were mere rationalizations, expiations of guilt, which personnel used to solve their own conflicts about unsuccessful relationships (or avoidance of relationships) with difficult patients.

The "sociopsychiatric" nursing approach can be readily applied to everyday ward care. The aide or nurse is in the unique position of being the person who spends the most time and lives most closely with the patient. During a bath, meal, or walk or casual conversation she observes how the patient responds and can become aware of how she, in turn, feels and reacts towards him.

Reorganization of ward responsibilities is sometimes necessary to provide aides and nurses with opportunities to be with patients in a variety of situations.

When a particular aide or nurse has had a series of successful contacts with a patient, the sharing of these experiences will be of value to the other personnel. If there is an opportunity for them to discuss their observations many attitudes will be clarified and a joint plan of action can be developed.

The psychiatrist can bring to the conferences his insight and knowledge of patient dynamics, and because of his role, can offer a more detached perspective in the discussion and solution of daily problems.

Joint planning has several advantages. If all are working toward the same goal, any plan devised has a greater chance of succeeding. Even if it does not succeed, the combined thinking of the group will help determine the reasons for failure, and a new plan may be formulated. Simultaneous participation of several staff members in working with a patient provides the patient with opportunity to relate to a number of people and also insures continuity of care.

Public Relations

N.Y. DEPT. OF MENTAL HYGIENE RELEASES EDUCATIONAL CALENDAR

THE NEWEST PUBLIC EDUCATION medium being employed by the New York State Department of Mental Hygiene is a two-year calendar "advertising" sound mental health. Its theme is "Mental Health is for Every Day" and each page carries brief reminders of the principles of mental hygiene. These are humorously illustrated by actions of the first family of the cartoon world: The Bumsteads, Blondie and Dagwood, plus their two children and six dogs.

The calendar marks the fifth appearance of the Bumsteads as mental health messengers for the Department's exhibit at the New York State Fair. Previously they have been featured in a comic book, an animated exhibit, a puppet show and a bookmark, all designed to demonstrate to their human counterparts that mental health can and should be cultivated in everyday activities. As Dr. Newton Bigelow, Commissioner of the Department, writes in the calendar, "Every year has 365 precious days. Mental Health is the thing that helps you make the most of each one."

Single copies of the calendar can be obtained free by writing to the Department of Mental Hygiene, in Albany.

This Month's Cover

The majority of psychiatric hospitals were originally built in the country or on the outskirts of cities and towns. However, the rapid growth of surrounding communities since has resulted in all too many hospitals being surrounded today by residential areas or business districts.

Whereas in the old days patients of all types could be permitted out on the hospital grounds with minimal supervision, they cannot today be given too much freedom lest they walk into areas dangerous both to themselves and to the community. Numerous nurses, aides and technicians are needed to supervise outdoor recreational activities. Patients who are constantly watched and cautioned have no sense of freedom and their frustrations are increased. Moreover patients in an urban hospital have little privacy. Morbidly curious sightseers are often attracted to the grounds in congested areas.

The Neurological Hospital in Kansas City, Mo., solved the problem by enclosing an area 60 x 100 feet with a 10 foot high double fence (see cover.) By staggering the redwood boards, ventilation is secured and privacy maintained. The snack bar has floodlights on top so that night activities are possible in the hot weather.

This is of course a "pen"—a "stockade," but we do not agree that the restrictions it entails are out of keeping with modern psychiatry. Many playground areas, both public and private, are fenced in today so that children and adults may have freedom within the area. We are even beginning to fence in our own back yards, both for privacy and security.

In this area patients have complete freedom. Nobody says "Don't go too far," or "Stay with the group." Nobody has complained about feeling hemmed in. The patients love it, and the only difficulty is in keeping our folks indoors long enough to see the doctors and take their treatments. Moreover, two or three people, and often only one, can take care of 35 to 40 patients. At night no guards are needed to keep patients from wandering off. One or two aides or nurses can control the situation without difficulty.

G. Wilse Robinson, Jr., M.D.,
Associate Medical Director.

CALIFORNIA MONTHLY REPORT AVAILABLE ON LOAN

Dr. Frank Tallman, Commissioner of Mental Health for California, whose article on appropriations appeared in our September issue, has generously made available a few copies of his activity reports, which are prepared monthly for the Governor's Council. These reports are typical of the department's year-round education program.

Copies may be borrowed from M.H.S. Loan Library for two weeks only. Please send 15c *in stamps* for handling and mailing charges.

NEWSPAPER PUBLICITY SWELLS FUND FOR TV SETS

THE GIVING of television sets to mental hospitals is becoming an increasingly popular form of donation, both from relatives of patients and from organizations. The Wayne County General Hospital in Eloise, Mich., took advantage of one such presentation to secure some newspaper publicity. The result was a flood of contributions, ranging from $1 to $500, to purchase additional sets, as well as offers of actual equipment.

A television fund was established to accept these gifts and to purchase sets as sufficient money was accumulated. This TV fund also provided a solution to the problem of what to do with undesignated contributions or with offers of gifts which could not be distributed equitably.

The hospital soon had 22 television sets on its psychiatric wards, plus several others for chronic and infirmary wards of the Medical Division. It also had enough money on hand to purchase ten or fifteen more sets. (2-1)

General Medicine & Surgery

DENTURE IDENTIFICATION METHODS VARY

FROM UTAH STATE HOSPITAL at Provo comes the information that they use the system of putting the patient's own name in his denture for identification purposes. They find it simpler than using a code system of any kind. The name is typewritten on a narrow strip of very thin paper, and this name plate placed on the gum side of the denture. A layer of clear acrylic is laid over the name plate and held in place with cellophane. The denture is then pressed, separated and any excess material trimmed before final processing. In old plates, a section is cut out large enough to take the name strip.

Eastern State Hospital, Virginia, uses the patient's full name on new dentures, but uses a code system from one to ninety-nine with alphabetical prefixes on plates already in patients' possession. This combination, the department claims, is as effective as automobile license plate numbers.

Architecture

NEW BUILDING AT BUFFALO STATE

THE FIRST TWO HUNDRED PATIENTS were moved into the newly completed 617-bed medical and surgical building at Buffalo State Hospital late in August. The building will be formally dedicated in October.

Completion of this facility, which cost $4,747,000, will relieve serious overcrowding at the hospital, which necessitated using improvised quarters in corridors, dayrooms and other sections not intended for ward use. The return of these sections to their proper uses will much improve the arrangements for the care and treatment of all patients.

The new building concentrates medical, surgical and diagnostic facilities under one roof. Wards for medical care, formerly scattered throughout the hospital, will be in this building, which will also contain facilities for specialized therapies, including shock, and auxiliary services like clinical laboratories. This is the first major new construction at the hospital since 1931.

The Buffalo building is the second of several similar medical and surgical buildings provided for in the current building program of the New York Department of Mental Hygiene. The first to be completed was a 960-bed facility dedicated last June at Hudson River State Hospital, Poughkeepsie. Nearing completion are two more buildings at Binghamton State Hospital and Utica State Hospital. Medical-surgical buildings in various stages of planning include units at Manhattan and Rochester State Hospitals. (2-1)

THE WORK OF THE MODEL REPORTING AREA

(Continued from page 5)

and the follow-up of first admissions.

A number of the 11 States have started or will shortly start a central reporting system of therapy data. As a result of participation in a pilot study in 1950, conducted by the N. I. M. H. with the Model Reporting Area, several of the States have also inaugurated cohort studies on first admissions for the year from July 1, 1952 through June 30, 1953 over a five-year period. (A cohort study is a study of a group of patients with certain factors in common followed during a given period of time to ascertain what happens to them; for instance, a group of patients first admitted in 1948 of a specific age, sex, and diagnostic category, followed for a specific period.) The variables to be controlled in this pilot cohort study are age, sex, race, disorder, and, where available for tabulation, therapy.

The pilot study will make it possible to evaluate therapy and to ascertain the probability of (a) release, (b) death, and (c) continued hospitalization within a given period of time—in this case, 5 years. Concretely, this will enable the medical staff to look at the individual elements of the hospital population more carefully and to evaluate what happens to them. In addition, it will provide a body of factual data so that the public can be informed more clearly about what happens to hospital patients of specific diagnostic categories, age and sex.

It is the hope of those professionally concerned that all States will begin to develop and expand their statistical offices and to standardize and tabulate their data in a uniform manner, with the intention of joining the Model Reporting Area as soon as possible.

Commissioners report on current Appropriations

Only ten Legislatures met in 1952, and in order to help the much larger number of State mental health departments which will request appropriations in 1953, the Commissioners of some of these states have most generously given us information as to their success or failure.

Dr. Joseph P. Barrett of Virginia explains that their appropriations are made on a biennial basis. For the biennium 1952-54 they requested a total of $24,017,248 for all purposes, including mental hygiene clinics and the State mental hygiene education program. Of this the Virginia Legislature granted $20,114,895, representing an increase of 36% over their appropriations for the previous period.

Dr. Barrett explains that prior to the meeting of the General Assembly the department had carried on an intensive education program, largely through the assistance of such statewide organizations as the Mental Hygiene Society of Virginia, the Business and Professional Women's Clubs, the Federated Women's Clubs, the League of Women Voters, the Junior Chamber of Commerce, the P.-T.A., the Citizens' Committee for Better Mental Hospitals, and so on. These groups organized mental hygiene programs at their general and local meetings, at which speakers gave information regarding the scope of the mental health program and the needs of the department in order to carry out this program.

There was, says Dr. Barrett, a great surge of public interest, and after the legislature convened, one of their ardent supporters arranged for a hearing before the joint sessions of House and Senate at which film strips were presented, showing conditions in the State hospitals.

In Colorado the appropriations requested for the Mental Hygiene Section of the Department of Public Health were denied, but the State Hospital at Pueblo received an increase from $4,500,000 to $5,300,000. This, with other sources of income, gives the hospital an operating budget of $6,150,000 from July 1st, 1952 through June 30, 1953.

Nor did Kentucky get its total requested appropriation. However, at a special session in 1951 an extra $500,000 was granted. This amount was increased by $300,000 in this year's budget, and next year a further increment of $600,000 is expected.

Dr. Gaines writes that they did not have any formal campaign or produce any literature. But several members of the Kentucky Association for Mental Health did some intensive lobbying, and one particular member spent almost all her time at Frankfort while the Legislature met there. She used reprints of an article from *Life* magazine in talking to legislators.

The Chairman of the Board of Institutions in Louisiana writes that the members of the State's Legislature are quite conscious of the needs of mental institutions and that little difficulty was experienced in obtaining the requested appropriations.

From Massachusetts comes the information that they were granted a sum in excess of $40,000,000 for operation of institutions and clinics, the largest ever granted in the state. The appropriation includes authorization for expansion of some of the existing clinics and for the establishment of four new clinic units. They also obtained approximately $16,000,000 to continue their modernization and new building program.

Both Massachusetts and New Jersey, which is also very happy about its appropriations, indicate that they did not carry out any special campaigning or prepare any special literature. Dr. Jack Ewalt, Commissioner in Massachusetts, says that most of the work was done by talking with legislators personally, and that they had the whole-hearted support of the Governor and his Administrative Council.

Dr. W. P. Beckman, who became state director of mental health on September 1, writes that the maintenance appropriation for the South Carolina State Hospital was increased sufficiently to add 134 attendants and ten nurses. The Legislature also appropriated five million dollars for permanent improvements and repairs at the hospital and at the State Training School.

Governor James F. Byrnes had appointed a committee to study and report on the mental health needs in the state, and in his speech to the General Assembly last January laid much stress upon the needs of the state hospital, which he referred to as "Problem No. 1 for this legislative session." He concluded his appeal with these words:

"The State Hospital population is greater than the population of most county seats in this State, but notwithstanding their number, these patients are truly the forgotten people. Often they are forgotten even by their families. They have no lobbyists in the State House to ask for additional appropriations. They have no alumni association to plead their cause. If you hear a voice speaking on their behalf, it is the voice of your own conscience. I am sure you will be guided by that voice."

Administration

PATIENTS' RIGHTS EXPLAINED IN THEIR NEWSPAPER

THE SENIOR PHYSICIAN of Napa (Calif.) State Hospital recently published an article in the patients' newspaper entitled "Medical Aspects—You and the Law."

In this article, Dr. Richard C. Argens discussed frankly the patients' complaints that they were "railroaded," "rushed" or "framed" and points out that each one of them had to be admitted with strictest attention to the law of the State. He reminded them that a copy of the state Welfare and Institutions Code was available for their examination in the patients' library.

He discussed the question of civil rights of patients, and cases where the Court had declared some of them "incompetent" for their own protection. He explains that they have the right to ask for a jury trial and that they may engage their own lawyer. He made the point that few of these petitions are successful simply because the law has been complied with correctly.

He further told patients that every one of the therapists in a mental hospital, far from being anxious to keep a patient unnecessarily, is constantly seeking for those who have recovered sufficiently for release. "This is not only good medicine," said Dr. Argens bluntly. "It is also good economics. The goal of therapy is to have an ever increasing number of patients leaving the hospital."

The article was considered of sufficient interest and benefit for the patient newspaper at Patton (Calif.) State Hospital to reprint it in a recent issue for the benefit of their own patients. (1-1)

Mental Defectives

CLASSROOM IDEAS

Store account charts on the walls of sewing classrooms at the Polk (Pa.) State School enable the girls to get a painless dose of arithmetic with their sewing instruction. The charts list the "selling price" of each commodity used in class, and the girls enjoy figuring out how much their products would cost if the materials had been bought in a department store.

Desks for students confined to wheelchairs are improvised by attaching a plywood board, cut to shape, to the chair's armrests. A moulded rim helps keep papers from sliding off, and for spastic patients the papers are tacked onto the board. (17-2)

LATEST M.H.S. PUBLICATION: "DESIGN FOR THERAPY"

Mental Hospital Service is pleased to announce its latest publication, "Design for Therapy," the edited proceedings of the Conference on Mental Hospital Design, Construction and Equipment. This was the two-day meeting of leading mental hospital architects and administrators held last April in Washington under the auspices of the American Psychiatric Association.

A complimentary copy of this handsome 80-page booklet was sent last month to all hospitals and agencies which are regular subscribers to the Mental Hospital Service. Additional copies are available from M.H.S. at $1.25 each. A discount of ten percent is given on all orders of twenty or more.

Varied program topics for Fourth Institute

Superintendents and Medical Directors of public and private mental hospitals will probably comprise the largest single group attending the Fourth Mental Hospital Institute, advance enrollments indicate. Fairly close behind are administrators and business managers from hospitals and State and Provincial Offices with a substantial number of clinical directors, nurse and aide supervisors, and chaplains. As with previous Institutes, about 250 are expected and this is just about the right number to ensure good discussion. The meeting will open at 9 A.M., Monday, October 20, at the Deshler-Wallick Hotel in Columbus, Ohio. Below is an outline of the topics:

Monday, October 20

Mental Hospital Design, Construction Equipment, Furnishings (1½ hours)
Evaluating Patients' Progress (1½ hours)
Nursing Services (3 hours)
Banquet-Address by President Cameron, Presentation of Achievement Awards

Tuesday, October 21

(Simultaneous Morning Sessions—Two Hours Each)

Private Hospitals and Their Administrative Relationships with Public Authorities
Patterns of Organization & Administration of State & Provincial Hospital Systems
Care of Epileptics with Special Reference to Complications Presented by Mental Deficiency, Psychosis, and Behavior Problems
Patients Clothing—Therapeutic & Administrative Aspects

(Panel Discussion)

Pastoral Counseling in Mental Hospitals
The Child Patient and Children's Units
(Above topics will be considered for one hour in plenary session.)
Unified Hospital Reporting: Plans and Procedures for using the A.P.A. Diagnostic and Statistical Manual. Role of Mental Hospital Service in collecting data from Mental Hospitals (3 hours). Optional Informal Party (Evening)

Wednesday, October 22

Training Mental Hospital Administrators (1½ hours)
Academic Lecture: Practical Possibilities and Potentialities for the Development of Research in Mental Hospitals. Dr. J. S. Gottlieb, Professor of Psychiatry, State University of Iowa College of Medicine
Optional Afternoon Program: Visits to Columbus State Hospital, Ohio State University Medical Center, Columbus State School, Harding Sanitarium

Thursday, October 23

Vocational Counseling and Rehabilitation in the Mental Hospital (1½ hours)
Patient Follow-Up after Discharge, Community Care. Role of Out-Patient Clinic (1½ hours)
Care and Treatment of the Psychopath (1½ hours)

WORK PLACEMENT

(Continued from page 5)

social and moral habits which have sufficed him within the circumscribed environment of the institution must be strengthened to withstand the less compassionate scrutiny of the public.

The mentally retarded person must usually be taught these habits as a rote. A set of sex mores should be firmly impressed upon him so that he can always be counted upon to deport himself acceptably in relation to the opposite sex. Personal hygiene must be taught as a ritual. Appearance is a very important consideration in preparing the patient to work in the community. A simple thing like the right kind of hair styling or hair cut can often change a very defective looking person into a comparatively normal looking individual, and his clothing style should conform to that of the community.

Some thought should be given to the patient's leisure time potentialities. If he cannot participate in sports, then he should be encouraged to enjoy them as a spectator. Some hobby which he can enjoy by himself, such as wood carving or photography, will also furnish him a recreational outlet.

The patient's religious expression can play an important part in his community adjustment. He should be encouraged to attend the family church, and introduced to its pastor. Here, perhaps more than anywhere else, he will be accepted without reservation, and the affiliation will help him express his desire to succeed in the community.

One of the most difficult tasks, but one which must be done, is to give the patient some idea of his limitations. The persons he is to live with, whether it be family or employer, should also understand these limitations and the reason for them. They should be apprised, too, of the advantageous points of the patient's personality, and informed of his likes and dislikes. It is important that they be cautioned against expecting the patient to function beyond his prescribed limits, however good his community adjustment seems. The community is likely to forgive one or two minor mistakes or exhibitions of bad judgment or childishness, but the patient himself develops a sense of guilt and frustration when these bad experiences are compounded in his life. These problems, added to the strain of keeping up with his more fortunate fellows, may be too much for him to bear. Needless to say, the patient may then have to be returned to the institution and all the work which has gone into making him a self-supporting citizen is undone, perhaps beyond restitution.

The criteria listed above are those which we at Lapeer have found successful in our work placement program. Just as a merchant credits his profits to wise merchandise selection and sound retail methods, these standards might be considered "good business tactics" for the social service department, and thus for the institution. More important, however, they enable us to help these individuals, who might otherwise remain forever dependent, to take their place among other self-supporting, self-respecting members of the community.

STRUCTURAL ALTERATIONS

(Continued from page 4)

personnel and recruitment aspects of such a program, of the necessity of continuing staff education or of the administrative reorganization which structural alterations may entail. All are knotty issues and the writer would be the first to agree that correction of a hospital's structural deficiencies will not in itself insure a sustained improvement in the calibre of patient care. On the other hand, the fraudulent thesis which holds the physical setting to be irrelevant cannot be accepted.

With a clear understanding of the medical goals set by the hospital's professional staff, the superintendent now begins to refine and coordinate the recommendations of all divisions and services within his establishment, nicely balancing the understandable desire of each department to perfect its own functioning against the final result in terms of integrated hospital service. He must be prepared for importunities, for unreasoning adherence to convention, and for deficiencies in imagination as well as for valuable flashes of inspiration from unexpected sources, and for genuinely helpful recommendations from those directly engaged in the front-line tasks of hospital operation.

The superintendent will also think of his hospital in terms of visitors. Are parking spaces adequate and properly located? How can the visitor's initial impression of the hospital be improved? Can he reach his destination among the various hospital buildings more easily? What improvements are necessary in the surroundings in which he sees his wife, his son or his father? What can be done to maintain his interest in the patient's welfare over long periods of time?

He will want to think in terms of staff. What structural changes or additions can be made which will reduce waste motion, simplify recurrent tasks, save the appointment of an extra employee, make a material contribution to morale or free some member of the staff for more important duties? Is there adequate and attractive housing for employees? Should the recreational facilities be expanded? Are there a sufficient number of garages and parking spaces?

He will analyze problems of service, maintenance and safety. Do all buildings have loading docks, service entrances and satisfactory systems of vertical transportation? Are the plumbing and heating systems adequate to care for all contingencies? What is necessary in the way of fireproofing, tuck pointing, roofing and reflooring to assure the safety and continued usefulness of the structures? What changes are required in the hospital's road system to reduce noise, prevent accidents and increase efficiency?

Most important of all, he will think in terms of patients. What will be the classification of patients and how will new and existing beds be allocated among them? What will be necessary in the way of occupational therapy facilities, recreational space, gymnasia, a swimming pool and a chapel to establish the therapeutic program agreed upon by the medical staff? What changes in the food service will be necessary to meet the needs of each patient group? Which buildings will be connected with tunnels or

with corridors to allow for the ready movement of groups in all climatic conditions? What are the medical requirements for enclosed gardens, roof decks and exercise spaces? What will be the dayroom and dining room space, the number and size of offices and of treatment rooms?

Unless additions can be made to existing buildings, the necessary administrative and treatment facilities can ordinarily be added only through conversion of bedroom space and a reduction in the previously determined tentative capacity of the structure. Completely ideal results are rare, but improvements which are very much worth while can commonly be obtained.

The planned reconstitution of any hospital is a taxing job, requiring great patience, much thought and a large measure of hard work. The superintendent who takes the pains to develop a master plan for his hospital can take satisfaction in the knowledge that he knows where he is going. Today the chances are excellent that he will get there.

MENTAL HOSPITAL SERVICE PUBLICATIONS

—Price List—

MENTAL DISORDERS, DIAGNOSTIC & STATISTICAL MANUAL. $1.50 each

WORKING PROGRAMS IN MENTAL HOSPITALS. Proceedings of the Third Mental Hospital Institute. (1951) $2.50

MENTAL HOSPITALS 1950. Proceedings of the Second Mental Hospital Institute. $2.00

BETTER CARE IN MENTAL HOSPITALS. Proceedings of the First Mental Hospital Institute. (1949) $2.00

STANDARDS FOR PSYCHIATRIC HOSPITALS & CLINICS. 25 cents each, or five copies for $1.00.

PSYCHIATRIC NURSING PERSONNEL. 60 cents each.

RECREATIONAL TRENDS IN NORTH AMERICAN MENTAL INSTITUTIONS. 25 cents each, or five copies for $1.00

Cash or stamps only accepted for orders of less than one dollar. There is a 10% discount when twenty or more copies of any one publication are ordered. Libraries are given a 10% discount and booksellers a 20% discount on all orders.

NEW MEMBERS OF M.H.S.

The membership list of Mental Hospital Service now includes two foreign hospitals, Gaustad Sykehus in Oslo, Norway, and Colony Geel in Belgium. Arrangements are being made for the Parkside Mental Hospital in South Australia to join.

In this country, four more general hospitals with psychiatric units have joined, Loretto Hospital and St. Lukes Hospital, both in Chicago, Roosevelt Hospital in New York City and Hartford Hospital in Connecticut; three state institutions, Mendota State Hospital, Madison, Wis., the Psychiatric Institute, New York City, and Syracuse (N.Y.) State School; (Other New York state institutions are also coming in;) and the Veterans Administration Hospital in Brooklyn, N. Y.

COMMENTARY

A former mental patient, Matilda Sherlock, writes of her stay at the Westchester Division of the New York Hospital. The article, entitled "They Saved My Sanity", appears in the September issue of ***Today's Health*** (A.M.A.'s public education magazine.) Mrs. Sherlock's account of her hospitalization may interest mental hospital personnel as a well-written description of a patient's eye view (in retrospect) of life on the wards. She describes the hall where patients are sent prior to discharge: "Here life begins to approach the normal. Here are the cliques and rivalries, snobberies and jealousies you will find in any afternoon bridge club. And here I realized, for the first time, that insanity is a great leveler. . . . How patiently we had borne with each other when we were all stewing in the same hell! . . . How distant and unimportant racial and social prejudice had been."

The mammoth new Ohio State University Medical Center—"Five Hospitals in One"—is featured in the September ***Modern Hospital***. This article should be of particular interest to anyone planning to visit the Medical Center (which includes the Columbus Receiving Hospital) while attending the Fourth Mental Hospital Institute this month.

The September issue of ***Hospitals*** describes an unusual experiment in hospital dietetics administration—"Food Service By Contract". The Hospital Center at Orange, N. J., consisting of a general unit of 370 beds and a 41-bed orthopedic unit, put the management of their dietary department into the hands of a commercial food management concern. The administrator of the hospital and his assistant describe how this radical innovation is affecting the efficiency and economy of their hospital's dietary service.

Also of interest to dietitians is an article on recruiting non-professional dietary personnel, appearing in the August ***Hospital Management.***

The same issue carries a thorough exploration of "The Inadequacy of Hospital Insurance", which may shed new light on this problem which is faced by most private psychiatric hospitals.

Institutions, September issue, weighs the merits of plastic floor tile (vinyl) for institutional use. It lays heavy emphasis on its durability and anti-slip safety factor, as well as easy maintenance and decorative value.

Institutions presented a series of three articles on cost control in food service in its May, June and July issues. The third article deals with portion control. Hospital dieticians will be interested in its pointers on standardizing portions, minimizing meat shrinkage in roasting, and on cutting deep-fat frying costs.

"Industrial Arts Projects Become Therapy" in the April ***Bulletin of the American Association of Rehabilitation Therapists*** includes a chart to guide woodwork instructors in assigning projects to patients according to their physical and mental capacities.

Reprints Available:

A limited number of reprints "The Present Status and Future Needs of Psychiatric Facilities in General Hospitals in the United States and Canada" are available from M.H.S. The paper reports on the three year study conducted by Dr. A. E. Bennett and associates. It was first published in ***The American Journal of Psychiatry,*** November, 1951.

Single copies of "A Sociopsychiatric Nursing Approach to Intervention in a Problem of Mutual Withdrawal on a Mental Hospital Ward" are available free of charge by writing the National Institute of Mental Health, Bethesda 14, Maryland. This is the more comprehensive report of the study conducted by Gwen Tudor, R.N., and Morris Schwartz, Ph.D., which is outlined on page 7 of this issue. The full paper was originally published in the May, 1952 issue of ***Psychiatry: Journal for the Study of Interpersonal Processes.***

Dental health affects Mental health

BY J. J. HERNDON, D.D.S.

Director, Tharpe Dental Clinic
Milledgeville, Ga.

Good dental care programs have great value in connection with psychiatric treatment at many institutions for mental illness.

As long ago as 1899, Georgia's huge state hospital at Milledgeville recognized the need for dental treatment and a full-time dentist was added to the staff. With the hospital population increasing yearly, the dentist struggled alone for 25 years, and it was not until December 1924 that a second dentist was added.

Today, with a population of about 11,000 paients, from every one of the 159 counties in Georgia, Milledgeville is one of the largest mental hospitals in the world. Naturally the need for dental care has increased with the population. Two dentists could not adequately provide even the most extraordinary emergency care for the 11,000 patients, but lack of funds, lack of suitable buildings and lack of personnel kept the dental clinic struggling along doing the best it could up to the years of World War II.

The Georgia Dental Association was perhaps the prime mover in alerting public attention to the need for an up-to-date dental clinic, fully staffed, in the hospital. In the early days of 1950, Dr. Rayford Tharpe, an Austell (Ga.) dentist, became dental consultant of the State Department of Public Welfare. Governor Herman Talmadge had been elected, and Dr. T. G. Peacock had been appointed as superintendent of the hospital. Improvements were rapidly being made to medical and dental services in all state institutions.

Our need was so pressing that it was only a matter of months before sufficient funds were allocated. Architects and building engineers were employed and plans were made for one of the most modern and best equipped dental clinics anywhere in the nation. On a windy March day the ground was broken, and late in September, 1950, Governor Talmadge was the principal speaker at a dedication program marking the end of construction. As evidence of the interest of all Georgians in this event, there were hundreds of dentists, physicians, legislators, newspaper editors and ordinary citizens at the dedication. The new clinic was named the Tharpe Clinic in recognition of Dr. Tharpe's activities for the whole state. To show the taxpayers what their dollars had done we held "open house" on several occasions during the construction and equipping periods, and after completion. On February 15, 1951, the Tharpe Clinic formally began its work.

Dental work in a mental institution is vastly different from any other activity in the entire field of dental care. As a rule patients are well behaved, and often seem more appreciative than do the patients whom a dentist serves in his usual private practice.

It is amazing to note how the mental patients react to improvement in the appearance of their teeth. They seem eager to learn tooth-brushing technique so that the shine and gleam can be retained and they treasure the brushes issued to them.

There is no limit to the amount of money the state will spend to restore a patient to good dental health, but it would be a mistake to suppose that the taxpayers' money is spent too lavishly. In the new clinic there is every facility for providing superior dental care, including x-ray machines, laboratories for making prostheses, facilities for every kind of restoration, and the most modern methods against periodontal disease as well as all types of prophylaxis. We are justly proud of the equipment, which is the most modern available, and affords the maximum in technological assistance.

Most of the work at the clinic consists of extractions and making of dentures. Unfortunately a large percentage of patients have neglected their teeth for so long that little can be done to save them. Wherever possible, the teeth are saved even though it may mean a long drawn out series of treatments or operations.

Every patient admitted undergoes a thorough dental examination as soon as possible after his arrival. He is given prophylaxis. The treatment necessary is noted on his record and he is given appointments at regular intervals until the dental work is completed.

Thanks to public enlightenment as to the need, Georgia is now leading the way towards the maximum development of this vastly important aid to psychiatric treatment.

The dental clinic building was erected at a cost of $150,000. It is a two-story, air-conditioned, fireproof building, 150 feet by 50. All space is effectively utilized.

The first floor is entered at street level on the side of a slight hill, giving the building a ground floor. On this ground floor we have a large dental laboratory, a lecture room, a storage room, and two business or conference rooms.

On the first floor there are two reception rooms, one for white patients and one for Negroes. Segregation is a matter of State law in Georgia so this is mandatory. Also on this floor are the x-ray room, developing room, library, sterilizing rooms, two small laboratories, a business office, a private office and a linen room. We have 13 fully equipped operating rooms and two surgical rooms. There are two recovery rooms and two lounging rooms.

There are ten dentists on the staff, heading a long list of trained personnel, including an oral hygienist, 10 dental assistants, one oral surgeon consultant, two receptionists, one laboratory technician and two laboratory assistants, plus miscellaneous clerical and custodial employees.

Dental research is constantly carried on and there are regular dental staff conferences. On numerous occasions clinicians have addressed the dental staff, and the Central District Dental Society, a component of the American Dental Association, has held several of its scientific meetings here.

The dental library is growing fast, filled with standard tests, papers, and a widely diversified list of current dental professional publications.

Georgia's medical and dental professions have given us the finest kind of cooperation. Politics have been notably absent from the institution's affairs, and appointments to our dental clinic staff are based entirely on demonstrated ability.

Legislation

QUEBEC SURVEY INDICATES MENTAL HEALTH NEEDS

MENTAL HEALTH NEEDS were given much consideration in a recent survey carried out by a provincial health survey committee in Quebec, which was released in August by the federal health minister, the Hon. Paul Martin. The survey was financed by a federal health grant.

Recommendations in the mental health field include the appointment of a nurse in each district, trained in mental health; free mobile mental health clinics to help general practitioners and rural health units; the subsidization of homes to care for senile dementia patients; more schools for the retarded; increases in the quality and quantity of staff and equipment in mental hospitals; support for research in mental diseases; more attention to periodical studies of mental patients; better health education and increased hospital services for epileptics.

The report praised the universities for their leadership in psychiatry and the development of mental health clinics. (15-I)